M & C Taylforth Properties Ltd

Chaseside Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 29 June and 11July 2016 and was unannounced.

Chaseside Care Home is located in Lytham St. Annes, Lancashire. The home is registered to provide accommodation and care for up to 22 older people. The majority of people accommodated are living with dementia. At the time of our inspection there were 12 people who used the service.

At the time of this inspection there was no registered manager in place at the service. The previous registered manager left the service in November 2015. Since this date the provider had taken control of the day to day running of the home but had not applied to the Commission for registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The last inspection of this service took place on 18 November 2015. At this time the service was found to be in breach of regulations relating to good governance and person centred care and was awarded a rating of 'Requires Improvement.'

During this inspection we had ongoing concerns relating to the previous breaches. We also identified further breaches of regulations.

Risks to the health, safety and wellbeing of people who used the service were not always assessed or managed in an effective way. Some examples were found of risk assessments not being completed and other examples were found of risk assessments which did not contain current or accurate information. Where risks were identified, these were not always addressed through robust care planning.

We found that suitable arrangements were not in place to ensure that all staff had the necessary skills and knowledge to meet people's needs safely.

There were significant shortfalls in the service's recruitment procedures. We found several examples of staff being recruited and allowed to work shifts in the home without the appropriate background checks being carried out. This meant the safety and wellbeing of people who used the service was not protected.

The rights of people who were not able to consent to their care were not consistently protected as the service did not always work in accordance with the Mental Capacity Act and associated legislation.

People's privacy and dignity was not consistently promoted due to inadequate arrangements to protect their personal information.

The arrangements for monitoring the safety and quality of the service were found to be in ineffective. Audits viewed had not identified some significant shortfalls and had failed to assist in identifying areas for improvement.

Evidence showed that potential learning from adverse incidents was not always identified or acted upon.

When viewing rotas it was not always clear who was in charge at the home on particular dates. Rotas were not always properly completed to reflect this information.

We requested the provider's training records during and after the inspection to enable them to demonstrate their competence to carry out the role of registered manager. However, these were not provided.

Complaints were not always properly recorded. We did however, find evidence that the provider took action to resolve concerns raised.

Procedures for managing people's medicines were found to be generally satisfactory. Although some minor shortfalls in records were identified.

People we talked with spoke highly of staff and felt they were treated in a kind and caring manner. People expressed satisfaction with the standard of accommodation and the quality and variety of meals provided.

The provider and staff worked in partnership with community professionals to help ensure people's health care needs were met.

Meetings for people who used the service were held on a periodic basis. The provider attempted to gain people's views through processes such as satisfaction surveys.

During this inspection we found evidence of ongoing breaches of regulations in relation to governance and person centred care. We also found evidence of new breaches of regulations relating to consent, dignity and respect, safe care and treatment, safeguarding, staffing and recruitment.

Following this inspection the overall rating for this service is 'Inadequate' and the service has been placed in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service.
This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

You can see what action we have taken at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to the health, safety and well being of people who used the service were not always properly assessed.

The recruitment practices followed by the service did not promote the safety and wellbeing of people who used the service.

Sufficient numbers of suitably qualified staff were not always on duty which meant people were at risk of not receiving safe care.

Is the service effective?

Inadequate

The service was not effective.

The rights of people who did not have capacity to consent to their care were not consistently protected because the provider did not always follow the MCA and associated guidance in practice.

Arrangements for staff training and support were inconsistent and were not adequate to ensure all staff had the necessary skills and knowledge to carry out their roles safely.

People received appropriate support to access health care when they needed it.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's personal information was not always sufficiently managed in a way that protected their privacy and dignity.

People spoke highly of care staff and felt they were treated in a kind and caring manner.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Pre admission assessments were not always carried out in an effective manner.

Important information about people's needs was not always included in their care plans. This meant people were at risk of not receiving the care they needed.

The provider attempted to gain the views of people who used the service and their representatives.

Is the service well-led?

Inadequate

The service was not well led.

Processes to assess safety and quality across the service were not effective.

The provider did not have an effective system in place to ensure that any potential learning from adverse incidents such as accidents was identified and cascaded to the team.

Chaseside Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to review the rating for the service under the Care Act 2014.

The inspection took place on 29 June and 11 July 2016. The inspection was unannounced which meant the provider was not aware it would be taking place until we arrived.

The inspection team consisted of three adult social care inspectors.

Prior to our visit, we reviewed all the information we held about the service, including notifications the provider had sent us about important things that had happened, such as accidents. We also looked at information we had received from other sources, such as the local authority and people who used the service.

A Provider Information Return (PIR) was not requested for this inspection.

We spoke with four people who used the service, two relatives and the relative of a person who had recently used the service. We also spoke with five staff members, including the provider, the deputy manager and three care workers.

We carried out a pathway tracking exercise. This involved us examining the care records of five people closely, to assess how well their needs and any risks to their safety and wellbeing were addressed.

We consulted five community professionals throughout the inspection, including professionals from the local authority safeguarding team and the Local Authority Commissioning Department. We received feedback from three of them.

We reviewed a variety of records, including four staff personnel and training files, staff rotas, records of complaints and completed audits. We examined medicines administration records and viewed medicines

stocks for all the people who used the service.

Inadequate

Is the service safe?

Our findings

In the care files viewed we found risk assessment documentation designed to enable the manager to assess and plan for any risks to people's health and wellbeing. However, in some cases these were blank and had not been completed. Blank risk assessments were found for areas such as nutrition, developing pressure sores and falling, in some people's care plans.

We viewed the care plan of a person who had moved to the home from another service. We were aware from information received from the other service that there were some risks associated with this person's behaviour that had the potential to impact on other people. However, there were no risk assessments or risk management plans in place in relation to these behaviours.

We viewed the care plan of another person who was the subject of some concerns due to them previously leaving the home unescorted, despite their being legal authorisation in place to prevent them from doing so for their own safety. There was no risk assessment in relation to the possibility of this incident re-occurring despite the fact that the person had stated they would attempt to leave again, possibly by unsafe methods.

In several examples, we found there were risk assessments in place, which did not reflect changes in people's needs and as such, were not accurate. For example, we viewed a falling risk assessment in place for one person who was assessed as being at low risk in this area. We noted this person had fallen on a number of recent occasions. We found that this person should have been assessed as being at extremely high risk of falling when using the service's own risk assessment format.

We also viewed this person's risk assessment for developing pressure sores. We found that information about her mobility was out of date and inaccurate, which meant she had been wrongly assessed as being at low risk of developing pressure sores.

One person's falling risk assessment did not take into account the fact they were prescribed a medication known to increase the risks of falling. We also viewed an accident report stating that a person had fallen due to the fact they were not wearing footwear. However, the importance of wearing footwear was not stated in their risk assessment or care plan.

The above findings demonstrated a breach of Regulation 12 (1)(2)(a)&(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There were procedures in place designed to promote safe recruitment to help protect the safety and wellbeing of people who used the service. However, we found that these procedures were not consistently followed. We viewed the personnel files of four staff members and found that in all four cases, there had been significant shortfalls in their recruitment process.

In three out of four examples, staff members had commenced work at the service without a full DBS (Disclosure and Barring Service) check being in place. A DBS check highlights if a person has a criminal

record or has ever been barred from working with vulnerable people. In addition, three out of these four people had commenced work without any references being received. Only one reference, which confirmed dates of employment only, had been received for the fourth person.

There was no information on three of the files as to how the staff members' suitability for the roles had been assessed. One person's application form showed they had no previous experience of working in the care field. However, their first shift was a night shift, before which, no induction training had been provided.

Records of induction for the four people were viewed. In only one example, had the staff member been rostered on as an additional worker, so they could be provided with induction. In two cases the staff members' first shifts were night shifts with only one other staff member on duty. This meant they could not be supervised the whole time or provided with induction prior to carrying out their role.

The failure to carry out appropriate background checks, assess candidates competence for the role which they were applying for and provide adequate induction meant that the health, safety and wellbeing of people who used the service was not protected.

This was a breach of 19(1)(a)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We viewed the service's staff rotas, which showed that the home was consistently staffed to levels assessed as appropriate by the provider. At the time of the inspection there appeared to be an adequate number of staff on duty to meet people's needs.

Rotas did not always clearly show the designation of staff or who was leading shifts. On some weeks it appeared, when viewing rotas, that there was no manager or senior staff member on duty. However, we were advised that at these times, the provider had been present and on duty.

We also noted that staffing levels had recently been increased during some parts of the day. This demonstrated that the provider took the needs of people who used the service into account when staffing the home.

Whilst numbers of staff were found to be appropriate in line with the provider's assessment of people's needs, we identified concerns about the skill mix of staff on some occasions. Evidence earlier described of brand new staff members, some with no previous experience of care, being rostered to work their first shifts at nights, with only one other staff member, demonstrated that the provider did not have adequate arrangements to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed at all times.

This was a breach of 18(1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We carried out a tour of the home and found it to be well maintained. All areas of the home were noted to be clean, warm and comfortable. Communal areas and people's private accommodation was decorated and furnished to a high standard. However, we identified concerns about some of the locks used, which were of a design that meant people could be accidentally locked in from the outside. We also found the lock on the staff toilet, which also contained some potentially hazardous items, to be of an unsuitable design. This was pointed out to the provider who agreed to carry out checks of the locks and replace those deemed to be unsafe.

We viewed medicines stocks and records associated with medicines management. We found medicines

administration records (MARs) to be completed to a generally satisfactory level. However, we did identify one record as missing a photograph and another to contain hand written entries, which had not been witnessed or countersigned.

There were clear instructions in place in relation to those people prescribed medicines on an 'as and when required' basis. We also viewed the records of one person whose medication regime had recently been subject to a number of changes. The changes were complex in that some medicines were being reduced, as others were being increased over a set period of time. However, we were able to confirm that this had been managed well and in accordance with the prescriber's instructions.

However, when viewing the records of another person we found that the prescriber's instructions had not been clearly communicated on their MAR or within their care plan. We discussed this with the provider who agreed to update the information straight away.

When viewing one person's MAR and daily diary notes, we noted that on one date, an entry stated she had refused her medicines but her MAR stated that they had been administered. We passed this on to the provider and asked them to look into the matter. This indicated that staff did not always take care to ensure records were maintained in an accurate manner.

Medicines audits were carried out on a regular basis and stock balances were consistently maintained. We carried out a number of random counts of medicines and found all balances to be correct in accordance with the service's records.

All staff responsible for medicines management had been provided with training. Annual competence assessments were carried out to ensure that they maintained their knowledge and understanding of the area.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Several of the care plans we viewed did not contain any valid consent to care and treatment. In some examples we found blank consent forms, which were present in the care plans but had not been completed. In other examples we found consent forms that had been signed by family members, without any evidence they had legal authority to give the consent.

This was a breach of 11(1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We viewed the plans of several people who were subject to DoLS applications made by the provider. In a number of cases we found that mental capacity assessments had not been completed prior to the applications being made.

We viewed the care plan of one person who did have a completed mental capacity assessment in place. This assessment stated that the person did not have capacity to make decisions about their accommodation or care. We were able to determine through discussions with staff that they were not free to leave the home unescorted but a DoLS application had not been made. Their care plan stated that a DoLS authorisation was not required.

We also viewed the care plan of a person who had recently left the service after a five week stay. There was no mental capacity assessment or DoLS application completed on behalf of this person. However, when we viewed their daily diary notes we saw that they had repeatedly requested to go home throughout their stay.

These failings demonstrated a breach of 13(5) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We did however view the care plan of one person who had been assessed as lacking capacity to make decisions about their care and accommodation and who had been deemed as requiring constant supervision to maintain their safety and wellbeing. We saw the provider was working closely with the local

authority in this example and taking steps to address concerns with them.

We viewed records relating to training and spoke with the provider and staff. We identified concerns about induction training provided to new staff members. There was an induction programme in place, which covered a number of areas designed to support new staff members in understanding their roles. However, we found this was not consistently followed.

We looked at the induction records of four people who had recently started to work in the home. None of the induction records were complete. In one example, of a person who had only worked a 'one off' shift at the home, there were no induction records. The records belonging to the remaining three staff members showed that large parts of their inductions had not been completed. This meant for example, that one person had not received their initial training in relation to safeguarding and mental capacity, despite having worked at the home for over seven weeks.

The provider advised us that new staff members were usually rostered on as supernumerary (additional to the usual staffing levels), so they could be provided with induction prior to being required to perform any additional duties. However, in three out of the four examples, we found this had not been the case. In two examples, new staff members had been rostered on to work night shifts and were not supernumerary. Neither of these new staff members had any experience in care work.

We also found some discrepancies with induction records. Some were not signed. Another was signed to state that induction had taken place on a day when the person who was recorded as having provided the induction, was not on duty.

A further concern was identified in relation to the content of induction training. According to the induction records a new staff member was expected to cover a very large numbers of areas on some days. For example, on one day the programme covered areas including Health and Safety, Infection Control, Accidents, Laundry, Moving and Handling, Bathing a Resident and Continence. It was not possible to cover all these areas in sufficient depth on one day.

Training for staff was provided mainly by way of 'e learning'. Records showed that a good amount of training had been completed by some staff members, which included DoLS, first aid, health and safety, infection control, moving and handling, record keeping, risk assessing, medication awareness and safeguarding. However, there were no training records in place for the four staff member recently appointed to the home.

Records showed that only five members of the staff team had completed training in supporting people with complex behaviours. As there were several people who used the service with behavioural needs this was of concern.

The above findings demonstrated a breach of regulation 12 (1) (2) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Most care plans viewed demonstrated evidence that the provider and staff worked with community health care professionals in a positive manner to help ensure people's needs were met. For example, we saw evidence of joint working with district nurses, GPs and dieticians.
We also noted that the provider referred any concerns about people's mental health to the relevant professionals in an attempt to obtain effective support for them.

However the care plan of one person who had recently left the home after a five week stay, contained no

medical history. This was also the case for a newly admitted person we tracked on the second day of the inspection.

Risk assessments were in place in relation to nutrition. However, these were not always completed. We found blank nutritional risk assessments in several people's care plans. We found a blank nutritional risk assessment in one person's care plan but did however, note that the provider had taken some action in response to the fact they had been identified as having a low weight and a poor appetite. This action included a dietician referral and monitoring of weight and food intake.

However, we viewed the records of another person who had experienced a significant weight loss over a short period of time and found that no action had been taken to refer them to a specialist or increase monitoring. Their daily records showed they refused their meals on a frequent basis but there did not appear to be any action taken in response to this.

People we spoke with expressed satisfaction with the standard and variety of food provided at the service. One person commented, "They cater for us very well in my opinion." Another advised us that one of the main reasons they liked the home was the standard of food provided.

Menus viewed were varied and nutritious. We noted that alternative meals were made available on a daily basis for people who did not want to have the planned meal. A staff member we spoke with advised us they were in the process of reviewing menus with people who used the service to ensure their preferences were taken into account as part of the menu planning process.

Requires Improvement

Is the service caring?

Our findings

In two people's care files viewed we found personal information about other people. It appeared that new templates had been made for risk assessments which had been photocopied on the back of assessments fully completed in respect of other people. This meant that people's personal information was not kept secure and their privacy was not consistently maintained.

CCTV was in place at the home and used in the majority of communal areas. Whilst the provider had some generic guidance in place in relation to the use of CCTV, it was confirmed that an individual privacy impact assessment had not been completed in relation to the home. In addition, there were no procedures in place regarding the accessing, storage and destruction of CCTV footage.

The above findings demonstrated a breach of regulation 10 (2)(a) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The majority of comments we received from people who used the service were positive. These included, "We are all happy here. All the ladies [staff] are very nice." "We are happy with what we have. I think they [the staff] are very good to us." One person who used the service referred to the deputy manager saying, "This lady is kindness itself."

However, we heard from one person whose family member had recently left the service. They told us that on the whole, they found staff to be caring and compassionate but felt there were 'a few' who appeared to lack interest. They said, "I found it all depended on who was on duty. Some [staff] were lovely but others just seemed like they didn't want to be there."

We observed staff providing support throughout our visits and noted this was done in a kind and respectful manner. One person we observed was feeling unwell and upset. Care staff were seen to spend time with her, patiently providing reassurance and supporting her at her own pace.

During our first visit we noted there was a calm and relaxed atmosphere in the home. Several people were having cups of tea in bed and we saw staff arrange breakfast in bed for one person. People were being assisted with personal care in their own time and when they wished to get up.

We saw care staff approach people in a respectful manner. Care was provided in a way that protected people's privacy and dignity. Care staff were seen to knock on people's bedroom doors for example and ensure people's doors were closed when providing personal care.

Some care plans we viewed contained a good amount of information about the person, the things that were important to them and how they wanted their care to be provided. However, in other examples, we found this sort of important information was missing.

Some people's care plans did not contain any social history or information about their important relationships, significant life events or previous employment. This sort of information helps staff to understand the individuals they are supporting. We also noted that some people's care plans did not contain information about their preferred daily routines, or what mattered to them about the way they were supported, which if present, would be valuable in assisting care staff to tailor care to meet people's personal needs and wishes.

In some cases we noted that where people experienced difficulties in communicating due to living with dementia, there was little information in their care plans about how to support them in this area. Detailed information about people's individual methods of communication would assist staff in supporting people to express their choices and decisions.

The above findings demonstrated a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

An advocate is an independent person who can assist people who use services in expressing their decisions and choices. Information was available for people about how to access local advocacy services. The provider and staff were aware of how to signpost people towards advocacy services if appropriate.

Requires Improvement

Is the service responsive?

Our findings

The majority of people we spoke with expressed satisfaction with their or their loved ones' care. We spoke with one relative who told us, "We are very happy with the care. It is good accommodation here and good food is provided." A person who used the service said, "I think I have everything I need here."

There was a procedure in place to assess the needs of any prospective resident prior to offering them a place at the home. This procedure was designed to help ensure that a person's needs could be met at the service. However, we found the process of pre-admission assessment was not always effective.

For example, we viewed the pre-admission assessment of one person who had moved from another service. The assessment was extremely brief and did not contain any reference to known risks associated with the person's behaviour. As such this area had not been risk assessed or planned for.

We viewed a selection of people's care plans. We found that a number of these contained gaps in information and did not fully address people's needs. For example, we viewed the care plan of a person who had recently left the service. We found that many parts of her daily care needs were not included on her care plan. A relative of this person has raised some concerns with us prior to the inspection as they felt that their loved one's care needs had not been met during their stay.

We looked at the care plan of another person who had been admitted three days before our second visit. Although the pre-admission needs assessment did provide some useful information, such as the preference of female staff and that they were relatively self-caring, there were a lot of gaps evident where information was lacking, such as sections for mental health, continence, eye sight, hearing and communication. Several of the questions on the assessment form were unanswered. No initial care plan had been generated and very limited risk assessments were in place.

We found examples of conflicting information in some people's care plans. For example, one person's care plan stated that they could become agitated and confrontational in one section but in another section stated 'shows no signs of challenging behaviour. Another person's plan described them as independently mobile in one section but in another, stated they required the support of a carer to mobilise.

We also found evidence that people's care plans were not always updated to reflect changes in their needs. For example, we tracked the care of one person who had experienced some ill health and deterioration in their general wellbeing. We noted that their risks in relation to falling and developing pressure sores had increased and that their needs in relation to mobility had increased significantly. However, this was not reflected in their care plan and no reviews had taken place of their risk assessments or care plans since their health had declined. This person's mobility care plan stated, 'independently mobile with zimmer frame' yet we observed them to require a great deal of support from staff when mobilising.

The mental health assessment of one person stated that they had no history of challenging behaviour or

aggression. However, a safeguarding alert had been raised several months previously due to them pushing another resident over.

The above findings demonstrated a breach of regulation of 12(1) (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We saw that some activities were provided, which included a visiting musician and some trips out on a one-to-one basis. One relative we spoke with commented that care staff sometimes supported her family member to enjoy a walk in the local park, which she enjoyed very much.

The majority of care plans we viewed did not contain any information about people's individual preferences in relation to activities or the support they required to engage in them. It is recommended that this be completed for every person who used the service to help ensure people's needs are met in this area.

Evidence was available to show that meetings for residents and their relatives were held periodically. Within these meetings, developments within the service were shared and people were invited to give their views about the service provided.

At the time of the inspection the provider had recently conducted a survey to ask people who used the service and their family members their opinions on standards within the home. The provider was waiting for responses which she advised us, she intended to analyse.

There was a complaints procedure in place, which provided information for people about how to raise concerns and included contact details of other agencies they may wish to contact, such as the Care Quality Commission and Local Authority.

A record of any complaints made, the outcome of investigation and action taken as a result, was available for inspection. However, on viewing this record, we were aware of one complaint which had been made by the relatives of a person who previously used the service. This was not recorded, although we were able to ascertain that the provider had taken steps to resolve the complaint at the time by meeting with the family. Failing to record complaints and action taken meant that opportunities to learn from complaints could be lost.

Inadequate

Is the service well-led?

Our findings

At the time of the inspection the service had been without a registered manager for approximately seven months. Throughout this time the provider had been managing the service on a day-to-day basis but had not applied for registration with the Commission.

People we spoke with were aware of the provider's role and who to speak to if they had any concerns.

We requested the provider's training records on a number of occasion to enable us to assess their competence. However, after several requests these were not provided.

Some previous rotas viewed did not show any manager as being on duty on several occasions. When we discussed this with the provider we were assured they had been present during these times but there was no documentary evidence to confirm this. It is important that rotas give a true reflection of who is on duty and who is in charge at all times.

Prior to the inspection we heard from two community professionals who shared concerns about the leadership of the service. Both professionals had been involved with the service due to safeguarding concerns raised. They both expressed a view that the service lacked strong leadership and that the provider had not engaged fully in opportunities to improve.

At the last inspection of the service we found the provider was in breach of the regulation in relation to good governance. We found that systems to assess and monitor the quality of the service provided were not effective. During this inspection we found that the systems had not improved and we identified ongoing concerns about governance.

Since the last inspection the provider had implemented a range of safety and quality audits. We viewed a selection of these but found they had not been carried out effectively. For example, several audits in relation to staff personnel files had been completed. These concluded that the quality of personnel files was in most cases the highest possible score and in the remainder of cases, the next score down, which translated as 'minor shortfalls'. However, on viewing four staff personnel files, we found each one had significant shortfalls in terms of the information they should have included.

A similar issue was identified with audits, which had been carried out of care plans within the service. Again, the majority of audits had scored the care plans as the highest possible score or as having only minor shortfalls. Our assessment of care plans was that there were a large number of shortfalls and areas for potential improvements.

Medicines audits had been carried out on a regular basis. These had failed to identify some potential improvements in relation to record keeping. The audits stated that there were no unwitnessed hand written entries in MARs and that all MARs contained photographs. These statements were not accurate.

We found the provider did not have systems in place to enable them to learn from adverse incidents such as accidents, complaints or safeguarding concerns. We spoke with a community professional who had been involved in the investigation of some safeguarding concerns raised by some relatives. Whilst the investigation had found the majority of issues to be unsubstantiated, the community professional had identified some areas for improvement and made some recommendations to the provider. However, the community professional reported that the provider had declined to engage with these recommendations.

We viewed a report which had been completed following an adverse incident involving a person who used the service. The report had a section on it entitled 'what have you learnt from this incident.' This had not been completed. The report stated that the information about the incident would be shared within the person's care plan. However, when we checked the person's care plan we found it had not.

When viewing records of falls we found four examples where staff had attributed the fact that the people had fallen to them not wearing slippers. However, there was no information in their care plans about this and there was no evidence that staff had identified this as a theme which should be addressed across the service.

We identified a number of breaches of regulation during this inspection, several of which related to areas of safety such as staff recruitment. These issues had not been identified by the provider. This demonstrated that the arrangements for assessing quality and safety were not effective.

The above findings demonstrated that our concerns in relation to governance identified at the last inspection in November 2015 had not been addressed. This was an ongoing breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Audits in relation to the environment including maintenance and housekeeping were in place and seen to be satisfactory. A range of certificates demonstrating that facilities and equipment within the home, such as fire safety equipment and lifting equipment, were regularly checked. Current gas and electrical certificates were available to show these facilities had been checked by external contractors.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that people's care was planned in line with their personal needs and wishes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that the service was provided in a manner that promoted people's dignity and privacy.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that legal consent for care and treatment was obtained from people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that risks to the health and safety of people who used the service were assessed and planned for. The provider had failed to ensure that staff had the skills to care for people in a safe manner.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure that people were protected from the risks of being unlawfully deprived of their liberty.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure there were systems in place to monitor the safety and quality of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure that there were safe recruitment procedures in place to help ensure the safety and wellbeing of people who used the service.